

BUILDING CAPACITY FOR RURAL HEALTH: THE ROLE OF BOUNDARY CROSSERS IN COALITION MATURITY FOR PARTNERSHIPS WITH EXTERNAL AGENTS

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ABSTRACT

The concept of partnership has entered policy rhetoric and is urged as good practice in a variety of domains including health. Rural communities tend to have fewer resources available for the provision of services such as health than their metropolitan counterparts, and so could be expected to benefit from partnerships with external agencies. Indicators of coalition maturity for working in partnership with external agents in order to build stronger communities are distilled from the group development and partnership research literature and considered in the light of the experiences of the University Department of Rural Health in community engagement. The chapter draws on experiences of two rural community coalitions working to plan and negotiate health service provision. The coalitions were analysed against the indicators. A key indicator of maturity and readiness for working in partnership with external agents is related to the behaviour of 'boundary crossers'. Boundary crossers are defined as people who move freely between two or more domains and who understand the values, cultures and language, and have the trust, of both. Domains can be within a community or be the community and an external sector. Community health professionals, especially those in senior positions, often act as boundary crossers between the community and broader domains such as regional/state health services or policy, although other community members can fill the role. Other key indicators of coalition maturity for working in partnership with external agents include local leadership that empowers the community, a willingness of community coalitions to take risks and mould opportunities to meet their vision, and a culture of critical reflection and evaluation of past actions.

This chapter analyses the impact of boundary crossing behaviour on community readiness and partnerships with external agents that are intended to build rural community capacity to plan and negotiate health service provision. It is argued that the characteristics and *modus operandi* of boundary crossers who are members of rural community coalitions affect the level of maturity of the coalitions and community readiness to work with external agents. An understanding of the characteristics and *modus operandi* of boundary crossers provides valuable insights for external agents in designing their approach to partnerships that build rural community capacity for health.

BACKGROUND

Community participation in rural health services in Tasmania is growing, driven by the community sector and emerging community engagement agendas of stakeholders such as governments and universities. Often evidence of partnership arrangements with both internal and external agencies are prerequisites of funding.

Rural health in Tasmania is dominated by State government owned facilities providing a range of health services, supplemented by several services operated under agreements between the three tiers of government. The University Department of Rural Health, Tasmania (UDRH) conducts a variety of community engagement projects in collaboration with rural communities.

Much of the UDRH's rural community support activity involves direct engagement with volunteer based community health advisory committees administered, in most cases, under the auspices of agencies such as local government. The aim of these committees is to formulate strategies to address community health and health service needs. The scope of their work varies, but virtually all committee constitutions, for example, have a collaboration clause. The UDRH provides support activities such as strategic planning exercises, mentorship for writing grant applications, community needs assessments and information brokerage. In the course of the UDRH's work, it has been noticed that some

community members who also had roles in local health services and had good links to other internal and external groups/agencies influenced the way the organisation engaged with its communities, and arguably, the quality of the outcomes. These people were frequently health service managers, though some were teachers, private health professionals or local government representatives.

COMMUNITY COALITION MATURITY AND PARTNERSHIPS WITH EXTERNAL AGENTS

Effective partnership harnesses the contributions of local partners and external agencies (Billett, Clemans & Seddon 2005). Our previous research in non-health contexts in rural communities has demonstrated that for external agencies "...the trick is to partner effectively with the communities to assist them to utilise and develop their social capital so they can respond to change" (Kilpatrick and Loechel 2004, p.15). Social capital is defined as "a set of resources that resides in the relationships among people and allows them to share their knowledge and skills" (Kilpatrick & Falk 2003, p.499), that is simultaneously drawn on and reproduced in collaborative action.

Many frameworks for assessing community group/coalition efficacy, maturity or readiness for working in partnership draw on social capital. The frameworks apply to partnerships for a variety of purposes; education (Billett, Clemans & Seddon 2005, Kilpatrick, Johns et al, 2002), natural resource management (Pretty & Ward 2001), participation in local governance (Cuthill & Fein 2005) and health (Johns, Kilpatrick & Whelan 2006). Social capital is a community asset that influences community well being, along with natural, physical, financial, and human capital (Pretty & Ward 2001). These are 'transformed by policy, processes and institutions to give desirable outcomes such as... better health' (Pretty 1999, p. 225). People and institutions are the means through which community assets are operationalised.

INDICATORS OF COALITION MATURITY FOR EXTERNAL PARTNERSHIPS

A framework for building the capacity of community coalitions which draws on an extensive review of the literature (Foster-Fishman et al 2001) includes the creation of positive external relationships, but restricts this to relationships with other community sectors, and is silent on relationships with agencies outside the community. We have previously analysed the maturity of partnerships between rural institutions (schools) and their communities (Kilpatrick, Johns et al 2002) and developed indicators of partnership maturity which we have applied to partnerships between rural health facilities and their communities (Johns, Kilpatrick & Whelan 2006). In that research, the outcome of a mature, effective partnership was found to be a sense of community ownership of the health service as a rural community hub, bringing together physical, human and social capital resources. Here, we take the indicators we developed and consider them alongside other frameworks and indicators of coalition maturity and/or community readiness. We develop a set of indicators for rural community coalition maturity to partner with external agents for the purpose of planning and negotiating health and wellbeing services. The indicators and their derivation from the various frameworks are shown in the Appendix.

Johns, Kilpatrick and Whelan (2006) identified an additional indicator of effective partnerships between rural communities and health services in local health managers. They often empower the community by employing a community development approach, and actively foster integration between health services and community. Cuthill and Fein (2005) support an empowerment approach to collaboration that 'begins within the community itself' (p.75), however they point out that power imbalances means the community is rarely able to achieve this. Local health managers are very well placed to empower the community from the inside because they understand both the community and external agency domains; and can thus be seen as boundary crossers.

BOUNDARY CROSSERS

'Boundary crossers'¹ were key players in development and operation of internal-external partnerships in our previous research in rural communities (Kilpatrick, Johns et al 2002). There, boundary crossers were those who spoke the language of both institution and community cultures, had the trust of both,

¹ The concept of boundary crosser was first used by Peirce and Johnson (1997) in relation to community leadership.

and provided a key link between them. The boundary crossers crossed internal community boundaries, some also crossed outside the boundaries of the community and assisted in bringing external resources to rural partnerships. Some, but not all, were employed by a local institution (school) which was part of a large multi-site agency.

Roles similar to our concept of boundary crossers have been described, and termed boundary spanners (e.g. Williams 2002), community organisers (Sutherland et al 1998), brokers and mediators. The role of broker or mediator, identified for example by Taylor (2000) in government facilitated community development, calls for individuals or institutions who stimulate the exchange of information and make connections across boundaries. The role of 'knowledge brokers' in public service agencies such as health, is to bring together those involved in the sometimes culturally and philosophically disparate fields of theory and practice (Canadian Health Services Research Foundation 2003). Boundary spanners in the organisational literature build bridges that link the organisation to its environment and 'serve critical communicative roles, such as bridges for bringing distinct discourses together, cultural guides to make discourses of the "other" more explicit, and change agents for potentially reshaping participants' discourses' (Buxton, Carlone & Carlone 2005).

Boundary crossers play a similar role by linking discourses, through an understanding of the language, values and culture of two 'domains'. They also build relationships and help find common ground. Where they differ from brokers or mediators is that boundary crossers are a part of two 'domains'; for example in the context of this paper, the community and the health service, or the local government and the community. We define boundary crossers as people who move freely between two or more domains and who understand the values, cultures and language, and have the trust, of both. Boundary crossers can do much to improve community outcomes, such as the match between community health needs and service delivery, however there may be circumstances in which this potential is limited or reduced.

Rural health professionals as boundary crossers

Rural health professionals' lives have been observed to be integrated into rural society, making it difficult to separate the personal from the professional (Lauder, Reel et al 2006). They are thus often 'boundary crossers'. Lauder, Reel and colleagues acknowledge the role of rural nurses as brokers within their communities in facilitating information flows, for example between the healthcare professions and patients.

Many health professionals in rural Australia are employed by government. Cavaye (1999) proposes a virtuous circle of contact between communities and public agencies to build community capacity. He argues that the role of government service delivery should be expanded to include community capacity building. Cuthill and Fein (2005) note there is a role for local government in building capacity of citizens to undertake collaborative local action for a sustainable community. Combining rural health professionals' capacity and willingness to boundary cross, and the urgings of Cavaye and others that public agencies engage in community capacity building, we asked: what is the role of rural health professionals in spanning the discourse boundary between the community and external agencies, and in brokering relationships and finding common ground between communities and external agencies?

THE DATA

Our data come from a pilot project that used multi-method, multi-site techniques to investigate effective health service–community partnerships in rural Australia. The methodology comprised case studies of good practice in two small Tasmanian rural communities, Deloraine and Southern Midlands, centred on the Oatlands township, and input from stakeholders through a project reference group. The two sites were selected to represent differences in terms of community characteristics (composition of the community, history of partnerships), however both feature a health facility operated by the State government, each servicing about 5500 people. Deloraine has a district hospital which recently underwent a major redevelopment, as well as the Meander Valley Centre for Health and Wellbeing, located on the hospital site. In Oatlands, the Midlands Multi-Purpose Health Centre was established through the efforts of a local Council-driven steering committee in response to increasing aged care needs within the municipality and an on-going threat of hospital closure.

Data were collected from three sources: individual and group interviews with relevant health service staff and community representatives, written documentation, and observation. Interviews were audio-

taped and later transcribed. Transcripts were analysed manually for themes and two in-depth case studies were prepared².

CHARACTERISTICS AND MODUS OPERANDI OF BOUNDARY CROSSERS

Each community had several people or organisations with the ability to cross boundaries between community and external agencies. These people were current or former employees of local and/or state government agencies. In Deloraine, the hospital's Director of Nursing (DON) links the two levels of government, because he is also an elected councillor. The Chair of the community-driven Meander Valley Centre for Health and Wellbeing committee is another boundary crosser, employed by the state education department. In Oatlands, a former local council employee played a key boundary crossing role in establishing the Midlands Multi Purpose Health Centre (MMPHC), while the current council General Manager played a hands-on role in negotiating a partnership between the council and the state health service (Tas Ambulance and the MMPHC) to enhance ambulance services in the region.

The skills, knowledge and networks of these people in drawing on and building community resources and facilitating interaction with external agencies are important in helping to secure resources for their communities. These boundary crossers all live in the community and see themselves first as community members, in addition to their professional roles. They are actively involved in the social and economic life of the community, have the ability to see and appreciate multiple perspectives because of their involvement in multiple groups and agencies and are committed to working in partnership.

In terms of their modus operandi, the boundary crossers identified in our research were deliberate and strategic in the way they operated, consciously building bridges within the local community, and between the local community and external agents. They used their formal position as government employees in multiple ways to facilitate greater community ownership of its health needs:

So I don't see myself as the council representative I see myself as a community player who can tap into council resources for good and ... [that's] how I see [the DON] ... and I don't think that we would say sorry this has gone beyond my brief because that's not the way that we operate. (Community Development worker employed by Meander Valley council)

Utilising a community development approach, boundary crossers have the ability to recognise the capacity of the community in terms of partnership readiness, and to build on that: 'so it's all about finding that structure and how the groups work ...'. Boundary crossers work with community groups to identify and articulate needs and issues for which joint solutions can be developed, and gradually upskill and empower others, rather than doing it for them. Using their informal and formal networks, boundary crossers help to match solutions to community health and wellbeing needs to available funding sources, assisting the community to amend or shift focus as necessary in order to meet funding criteria.

Boundary crossing behaviour impacts on community readiness through most or all of the indicators identified earlier, and particularly through empowering leadership, risk taking and moulding opportunities, and evaluation and reflective learning.

EMPOWERING LEADERSHIP

The ability and confidence of community members to leverage health services for their communities is an overarching capacity building strategy. It is underpinned by the need to 'get your facts straight – know what's going on'. In both sites boundary crossers assist community groups to identify and analyse health needs, and plan initiatives to meet them. While they coordinate data collection and write funding submissions, a key priority for effective boundary-crossing is to skill others to undertake these roles and give them confidence to use new skills.

Working with the Meander Valley Centre for Health and Wellbeing committee, the Deloraine hospital DON was firmly committed to skilling others to undertake leadership roles:

² Full copies of the two case studies are available from the authors.

How about we encourage other people here to have a go at this ... I can help you identify the grants, I'll help you write the submissions but you work with me and eventually you'll get up some skills I'm sure and you're all smart people.

This developed a community leadership culture, while also contributing towards sustainability of the committee and increased capacity to engage with external agents, because there are multiple drivers.

Boundary crossers have the ability to see the bigger picture, and assist communities to align their initiatives with existing or proposed government services or external sources of funding. However, they are not always directly involved in these negotiations because of their role as government employees. Instead they assist community groups by identifying which bureaucrats to target and how to present their proposal in order to ensure a positive outcome:

... I certainly assisted the committee on who to speak to and what to ask and what sort of information to provide. ... What we wanted to do was say to the [state health] department, and this was being a bit strategic, is we've got money, we've got plans, we've actually come up with a design for a facility and we want to build it on the hospital site to complement the services that you are doing. (DON, Deloraine hospital, regarding the location of the Centre for Health and Wellbeing)

Negotiations were facilitated because of the skills, knowledge and external networks of the Chair of the Centre for Health and Wellbeing committee, herself a state government employee.

Partnerships mandated by external agencies may develop more slowly as they try to find a balance between meeting pre-established terms of reference and playing a meaningful and purposeful role in community health and wellbeing. In Oatlands, the Site Manager of the MMPHC assisted members of the mandated Community Advisory Committee to explore new roles and alternative sources of power which saw them lobbying government ministers about a range of issues, including staffing, and the development of a new laundry for the MMPHC:

... the Community Advisory Committee made some strong approaches to the minister and other people and now we have our laundry, but many hospitals don't have that. (Hospital business support manager)

Buoyed by this success, a member of the Community Advisory Committee noted that

When you are tied to the council or the state government it makes decisions hard, so we went to both of them for help but we could make our own decisions ...

RISK TAKING AND MOULDING OPPORTUNITIES

Effective boundary crossers build trust through their own engagement with the community, both personally and professionally. At the same time, their high level of trust in others (staff as well as other community members), encourages these people to seek and develop opportunities for the benefit of the community. A Deloraine hospital employee, who has developed partnerships with external funding and service delivery bodies to address mental health issues, describes how

I'm trusted to do what I'm employed to do and there isn't that checking, it's very positive and I was welcomed and just to be trusted to do what I'm employed to do and given that autonomy and freedom to do that is—look, I can excel in my work.

There are a number of examples of how boundary crossers have assisted the community to initiate, plan and develop projects to meet local health needs while at the same time moulding their plans to meet the requirements of government or other funding bodies. Because of transport issues and the need to provide for its aged population, the Oatlands community needs a dedicated ambulance service with good local knowledge, available 24 hours a day. Tas Ambulance was not in a position to fully fund such a service. The hands-on boundary crossing behaviour of the local council General Manager saw the negotiation of a partnership between the council and two branches of the state health service (the MMPHC and Tas Ambulance). The partnership combines community resources with state health department funding, in a unique arrangement where volunteer drivers are paid by the council:

There was a bit of a mix-match where Tas Ambulance has taken on responsibility for the vehicle, all the equipment and the training, we [council] recruit and pay the drivers... the third party is the MMPHC who provide the nurses and doctors to sit in it.

In this case, pre-existing relationships established with the same senior health department personnel some years before during the establishment of the MMPHC, assisted in negotiating this new partnership.

In Deloraine, the DON worked closely with the community to refine and focus on an achievable project that would link identified community need for aged care respite services and improved local health service delivery, with available commonwealth and state government funding opportunities:

there were grand plans, other people had very different ideas and eventually the group developed a bit of an understanding of well, we can't do brain surgery here, but we can perhaps have a bit more of a primary health care focus, and we can look at potentially expanding our services, and once that was identified as a good thing to do and I came on board and actually found some funding to build a Centre for Health and Wellbeing ...

EVALUATION AND REFLECTIVE LEARNING

Boundary crossers can and should play a role in facilitating evaluation and reflective learning regarding community-driven health initiatives. Following the successful establishment of the Centre for Health and Wellbeing in Deloraine, the steering committee had achieved its original goal and undertook a process of evaluation and reflection in relation to its future direction. The DON facilitated the process by linking the committee to a state health department representative who helped them to identify options and reach a decision regarding ongoing management of the Centre and employment of diversional therapists. The DON and several other committee members also attended a workshop on community committee governance processes and structures, which resulted in a change of name to the Centre for Health and Wellbeing committee, and the development of a new mission statement that better reflected their new direction:

We achieved our initial purpose, and then once we had our centre, it became clear that we needed to become a management committee rather than a steering committee ... we also needed to revise our Mission Statement ... which is now to create and maintain holistic community-based health services in our area. (Chair, Centre for Health and Wellbeing committee)

In Oatlands, the Community Advisory Committee, working with the Site Manager of the MMPHC, makes a practice of evaluating past actions and initiatives, stating 'we always learn from something that we have done'. It is the plan of the Site Manager that the committee will become more actively involved in identifying and analysing health needs in the community, developing solutions to meet those needs, and evaluating the impact of those solutions. Through a process of upskilling and capacity building, and a broader focus on a range of health and wellbeing issues, the committee notes that 'we are tending to look ahead more'.

IMPLICATIONS FOR EXTERNAL AGENTS

Tapping into boundary crossers' intimate knowledge of the community and its capacity/ readiness to engage is a critical first step in the collaborative process. Enquiries through existing local networks help identify boundary crossers. Boundary crossers may not necessarily display specific characteristics or traits that distinguish them from other group members. In UDRH work, boundary crossers have been identified through displays of trust from fellow community members or empowering leadership. Trust is critical for gaining endorsement from the community for any proposed collaboration with the external agent. The boundary crosser can act as an advocate for the relationship. This is an important process as it shifts the overall benefits and risks associated with the collaboration away from the individual boundary crosser onto the broader community.

Through their knowledge of the community and other stakeholder agencies boundary crossers are often aware of other caveats to the engagement process that may need to be addressed. We are aware that a judgement based on a broader perspective may or may not be aligned with community perceptions or needs. There may be a fine line for boundary crossers between helping communities to

align their thinking and planning with existing or potential funding opportunities, and between inadvertently stifling community creativity and innovation because of their understanding of external values and priorities and the sorts of projects that are most likely to be externally funded. Similarly, where boundary crossers don't share their knowledge, or don't utilise empowering or enabling leadership practices and processes, they run the risk of creating a dependency culture within the community.

Our experience suggests that more effective boundary crossers, like those discussed in this paper, are skilled at working with other agencies to better align outcomes to community needs than may have been the case had the boundary crossers not been active. Given the potential influence and impact the boundary crosser may have in the engagement processes it is important that they are not regarded as a short cut in the community consultations process. Whilst boundary crossers have the potential to influence the direction of engagement, many also have to manage conflicting agendas which may limit their capacity to be a positive influence for change. In UDRH's community engagement experience boundary crossers are regarded as part of, rather than, separate from a whole of community engagement approach. This avoids the risk of bias and lessens the risk of a culture of dependency that may arise if knowledge is not shared with the community.

CONCLUSION

Boundary crossers can have a substantial influence on the effectiveness of partnerships between external agents and rural communities, including by facilitating risk taking and encouraging the moulding of opportunities and effective learning. They have access to knowledge and resources that can influence collaborative processes and the capacity of the community to address health issues. An understanding of the characteristics and *modus operandi* of boundary crossers provides valuable insights for external agents in designing their approach to partnerships that build rural community capacity for health, including by drawing on their empowering leadership. The location of the community on the set of indicators of coalition maturity outlined in this paper should be considered along with the nature and characteristics of the boundary crossers who are present, to formulate a customised, holistic approach to the partnership process.

This paper has revealed a gap in understanding of the operation of effective partnerships between rural communities and external agents. The set of indicators developed here requires further testing with other rural communities and in other, non-health contexts. We have suggested several ways in which the potential of boundary crossers could be limited, particularly not sharing their knowledge or empowering others and inadvertently stifling creativity and innovation. More research is needed to investigate under what circumstances such limiting occurs, and explore what training and support should be provided to maximise the effectiveness of boundary crossers, and who should provide it.

Appendix: Indicators for rural community coalition maturity for partnering with external agents for the purpose of planning and negotiating health and wellbeing services

Indicator	Derived from:
<i>Leadership contribution of community and external agent: reliance on external agents/networks, extent of community initiation of joint projects</i>	<p>Leadership is solely province of external agent at early stages, community is engaged at latest stages (3)</p> <p>Health service and community together play an active role in identifying and meeting community needs (4)</p> <p>Initiation of projects moves from external (early) to group (mature)</p> <p>Mature groups strong enough to resist external power (5)</p>
<i>Trust and working with the coalition: trust within coalition and partnership, attitudes and sense making of members, professionalism of procedures</i>	<p>Initial stage: build trust and formulate consistent, transparent and workable procedures. Sustaining stage: develop and support close relations and communication between partners (1)</p> <p>Effective groups have consensual view of purpose, do strategic planning, and have a cooperative culture built on social relationships (2)</p> <p>High level of trust amongst partners, health service and community; transparency, accountability and professionalism of processes</p>

Indicator	Derived from:
	important (4) Move from community climate is guarded at Denial stage to community supportive at later stages (3) Early stage: making sense of old realities, mistrust of the new and externally imposed rules and norms. Mature: expect change as the norm, develop and evolve own rules and norms, sharing within group and to and from external actors (5)
<i>External links and networks</i>	Sustaining stage: partners engage effectively with both community and external sponsors (1) Health service and community utilise extensive external networks (4) Early stage: few external links; vertical links are one way to and from above. Mature: well-linked to external agencies (5)
<i>Shared vision for community health</i>	Initial stage: Build shared purposes and goals (1) Ineffective groups concentrate on the operational, effective groups also articulate the underlying vision (2) Mid stage (Preparation): community has modest support for improvement efforts (3) Health service and community are committed to a vision centred on improving community health (4)
<i>Knowledge, use and valuing of community's resources: by community, health service and external agency</i>	Sustaining stage: recognise partners' contributions and facilitate new and strategic relationships (1) All available resources must be used effectively (2) Health service and community value skills of all (4) Latest stage (Professionalisation) sophisticated knowledge of community, high community involvement (3)
<i>Risk taking and moulding opportunities: Openness to new ideas, risk taking, willingness to mould opportunities to match vision</i>	Earliest stage (No awareness) 'its just the way things are' (3) Health service and community are open to new ideas, willing to take risks and willing to mould opportunities to match vision (4) Early: waits for and adopts external solutions. Mature: generates internal solutions; experimentation leads to adaptation and innovation (5)
<i>Evaluation and reflective learning</i>	Sustaining stage: actively reflect upon, review and revise goals, renew commitment (1) Effective groups: reflective learning informs planning and action (2) Latest stage (Professionalisation): extensive evaluation and modification (3) Evaluation of partnership (4) Mature group: critical reflection leads to new insights (5)

(1) Billett, Clemans & Seddon (2005) initial and sustaining stages

(2) Cuthill & Fein (2005)

(3) Edwards, Jumper-Thurman, et al (2000) nine stages from No awareness to Professionalisation

(4) Johns, Kilpatrick & Whelan (2006) effective partnerships

(5) Pretty & Ward (2001) early, mid and mature stage groups

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